

STATE OF MARYLAND - DEPARTMENT OF BUDGET AND MANAGEMENT

COBRA/LAWP/CONTRACTUAL/PART-TIME YEAR 2004 WORKSHEET

PERSONAL DATA

EMPLOYEE'S/RETIREE'S INFORMATION

Name:

Address:

City State Zip Code

Home Phone: () - - - - -

Work Phone: () - - - - -

Social Security Number: / / - - - - -

Date of Birth: / / - - - - -

Sex: ☐ Male
☐ Female

MARITAL

STATUS:

S ☐ Single W ☐ WidowedM ☐ Married D ☐ DivorcedL ☐ Separated

APPLICANT'S INFORMATION

(if different from employee's information)

Name:

Address:

City State Zip Code

Home Phone: () - - - - -

Work Phone: () - - - - -

Social Security Number: / / - - - - -

Date of Birth: / / - - - - -

Sex: ☐ Male
☐ Female

MARITAL

STATUS:

S ☐ Single W ☐ WidowedM ☐ Married D ☐ DivorcedL ☐ Separated

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

STATUS

- ☐ COBRA Date of Qualifying Event: _____
Are you on Medicare? ☐ Yes ☐ No
- ☐ Former Employee or Retiree OR Dependent of Employee or Retiree
- ☐ Former Contractual Employee or Dependent of Contractual Employee
- ☐ Former Satellite Employee or Dependent of Satellite Employee
- ☐ Former LAWP or Dependent of LAWP (Leave of Absence Without Pay)
- ☐ LAWP (Long Term Leave of Absence Without Pay)
Is this an on the job injury? ☐ Yes ☐ No
Effective Date of LAWP: _____
End Date of LAWP: _____
- ☐ Contractual -
Contract Period: From _____ To _____
- ☐ Part-time Employee (Less than 50%)
- ☐ Former Active Employee Now Working Part-Time (Less than 50%)

ENROLLMENT/CHANGE ACTION REQUESTED

- ☐ Open Enrollment
- ☐ New Enrollment
- ☐ Cancel All Coverage in All Plans
- ☐ Change in Family Status
- ☐ Add spouse/dependent because of:
- ☐ Marriage. Date: _____
- ☐ Birth/Adoption/Appointed permanent legal guardian.
Date: _____
- ☐ Resumed student status. Date: _____
- ☐ Other: _____
- ☐ Remove spouse/dependent because of:
- ☐ Divorce/Limited Divorce. Date: _____
- ☐ Death of: _____ Date: _____
- ☐ Dependent no longer eligible - Effective: _____
- ☐ Other: _____

Medical Benefits

OPTIONS

- ☐ New Enrollment or Change in Plan
- ☐ Change of coverage level
- ☐ No, I do not want to start this benefit
- ☐ Cancel all medical benefits coverage

COVERAGE LEVEL

- ☐ Individual Only
- ☐ Individual plus one child; specify _____
- ☐ Individual plus spouse
- ☐ Individual plus two or more
- ☐ End Stage Renal (ESRD)

MEDICAL PLANS

PPO Plans:

- 1 ☐ BC/BS PPO
- 2 ☐ MLH Eagle PPO

POS Plans:

- 1 ☐ Aetna POS
- 2 ☐ BC/BS MD POS
- 3 ☐ MD IPA Preferred POS

HMO Plans

- 1 ☐ BlueChoice HMO
- 2 ☐ Kaiser HMO
- 3 ☐ Optimum Choice HMO

Vision benefits are included in all Medical Plans. Contact Medical Plan for Vision benefits.

If you or a dependent have Medicare, write in name, Medicare number, effective date of Medicare coverage level.

Name _____ Medicare Number _____ Date of Coverage ____/____/____

Name _____ Medicare Number _____ Date of Coverage ____/____/____

ENROLLMENT FOR YEAR 2004**ENROLLMENT WORKSHEET****Prescription Coverage****OPTIONS**

- ☐ New enrollment
☐ Addition or removal of dependent
☐ No, I do not want to start this benefit
☐ Cancel current coverage

COVERAGE LEVEL

- ☐ Individual Only
☐ Individual plus one child; specify _____
☐ Individual plus spouse
☐ Individual plus two or more

Prescription Drug is not included in any medical plan. You must be enrolled in the Prescription Drug Plan if you want this benefit.

Dental Coverage**OPTIONS**

- ☐ New enrollment or change in plan
☐ Addition or removal of dependent
☐ No, I do not want to start this benefit
☐ Cancel current coverage

COVERAGE LEVEL

- ☐ Individual Only
☐ Individual plus one child; specify _____
☐ Individual plus spouse
☐ Individual plus two or more

DENTAL PLANS

Check only one dental plan:

- 1 ☐ Dental Benefits Providers
 DHMO
 Or
 2 ☐ United Concordia DHMO
 Or
 3 ☐ United Concordia POS

Dental is not included in any Medical plan. You must be enrolled in a Dental Plan if you want this benefit.

**Personal Accident and Dismemberment Benefits
 Available to LAWP/Contractual/Part-Time Only**

(NOT AVAILABLE TO COBRA ENROLLEES)

For Contractual/Part-Time Employees Only:

OPTIONS

- ☐ New Enrollment or addition/removal of dependent
☐ Change of benefit amount - make a \$ selection
☐ No, I don't want to start this benefit
☐ Cancel current coverage

COVERAGE LEVEL

- ☐ Employee only coverage
☐ Family coverage

BENEFIT AMOUNT

- ☐ \$100,000
☐ \$200,000
☐ \$300,000

For Employees On LAWP (Effective 1/1/2004)

- ☐ I want to continue my coverage
 Make a \$ selection

 ☐ Cancel my coverage

Spending Accounts - Health Care and/or Dependent Care

***For Employees Who Had Spending Accounts on Active Status In 2004**

THIS IS NOT A PRE-TAX BENEFIT AND FUNDS MUST BE WITHDRAWN BY 4/15/2005

AK Health Care Spending Account

- ☐ I want to continue my Health Care Spending Account in 2004.
 I understand that I will be billed for the same total \$ amount
 as in active plus a 2% fee for COBRA enrollees.
☐ Cancel my Health Care Spending Account.

AN Day Care Spending Account

- ☐ I want to continue my Day Care Spending Account
 in 2004. I understand that I will be billed for the same \$
 amount as in active status, plus a 2% fee for COBRA enrollees.
☐ Cancel my Day Care Spending Account.

ENROLLMENT FOR YEAR 2004

ENROLLMENT WORKSHEET

Life Insurance (AX) - Benefits Available to LAWP/Contractual/Part-Time Only

APPLICANT LIFE INSURANCE (NOT AVAILABLE TO COBRA ENROLLEES)

**For Contractual/Part-Time Employees Only:*

- ☐ Yes, I want to continue my 2004 level of coverage, Make a \$ selection.
- ☐ Yes, I want to continue my Life Insurance, but at a different coverage level. Make a \$ selection.
- ☐ Yes, I want to enroll as a new enrollee in Life Insurance. Make a \$ selection.
- ☐ No, I do not want to start this benefit
- ☐ Cancel all Life Insurance (applicant and dependent)

- ☐ \$ 10,000
- ☐ \$ 20,000
- ☐ \$ 30,000
- ☐ \$ 40,000
- ☐ \$ 50,000

NOTE: If you choose an amount \$60,000 or over, you must attach a Statement of Health to this form.

- ☐ \$ 60,000 ☐ \$ 110,000 ☐ \$ 160,000 ☐ \$ 210,000 ☐ \$ 260,000
- ☐ \$ 70,000 ☐ \$ 120,000 ☐ \$ 170,000 ☐ \$ 220,000 ☐ \$ 270,000
- ☐ \$ 80,000 ☐ \$ 130,000 ☐ \$ 180,000 ☐ \$ 230,000 ☐ \$ 280,000
- ☐ \$ 90,000 ☐ \$ 140,000 ☐ \$ 190,000 ☐ \$ 240,000 ☐ \$ 290,000
- ☐ \$ 100,000 ☐ \$ 150,000 ☐ \$ 200,000 ☐ \$ 250,000 ☐ \$ 300,000

***For Employees on LAWP:**

- ☐ I want to continue my life Insurance at the same \$ value as in active status. Make a \$ selection.
- ☐ No, I do not want to start this benefit
- ☐ Cancel all Life Insurance (applicant and dependents)

DEPENDENT LIFE INSURANCE (NOT AVAILABLE TO COBRA ENROLLEES)

For Contractual/Part-Time Employees Only:*Life Insurance on Spouse**

- ☐ Yes, I want to continue my spouse's life insurance at the 2004 level.
- ☐ Yes, I want to continue my spouse's life insurance, but at a different amount. Mark a \$ selection.
- ☐ Yes, I choose Dependent Life Insurance for my spouse. Mark a \$ selection.
- ☐ No, I do not want to start this benefit.
- ☐ Cancel Life Insurance on spouse.

Fill in the amount Amount of Benefit

\$, ☐ ☐ ☐

(Available up to 50% of employee's coverage in increments of \$5,000 only.)

Life Insurance on Child(ren)

- ☐ Yes, I want to continue my child(ren)'s life insurance at the 2004 level. Mark a \$ selection.
- ☐ Yes, I want to continue my child(ren)'s life insurance, but at a different amount. Mark a \$ selection.
- ☐ Yes, I want new life insurance on my child(ren). Mark a \$ selection.
- ☐ No, I do not want to start this benefit.
- ☐ Cancel Life Insurance on child(ren)

Fill in the amount Amount of Benefit

\$, ☐ ☐ ☐

(Available up to 50% of employee's coverage in increments of \$5,000 only.)

If you choose an amount over \$25,000 for your spouse and/or child(ren) you must complete a Statement of Health Form for your spouse or children.

For Employees on LAWP (Effective 1/1/2004)*Continue Life Insurance on Spouse**

- ☐ I want to continue my Dependent Life Insurance on my spouse at the same \$ value as in active status. (Mark a \$ selection above.)
- ☐ Cancel Dependent Life Insurance on my spouse.

Continue Life Insurance for Child(ren)

- ☐ I want to continue my Dependent Life Insurance on my child(ren) at the same \$ value as in active status. (Mark a \$ selection above.)
- ☐ Cancel Dependent Life Insurance on my child(ren).

COBRA - Consolidated Omnibus Budget Reconciliation Act

Mark one of the following:

Mark one of the following:			
QUALIFYING EVENT	PERIOD OF TIME ELIGIBLE FOR CONTINUATION*	QUALIFYING EVENT	PERIOD OF TIME ELIGIBLE FOR CONTINUATION*
<input type="radio"/> 1. Terminated employee (other than for gross misconduct)	18 months or until eligible for group coverage through another source including Medicare	<input type="radio"/> 6. Spouse of a State employee who has elected Medicare as primary coverage and the spouse is not eligible for Medicare	36 months or until eligible for group coverage through another source including Medicare
<input type="radio"/> 2. Resigned	18 months or until eligible for group coverage through another source including Medicare	<input type="radio"/> 7. Previously dependent child of an employee who is no longer eligible by reason of age, marriage, loss of student status or death of employee	36 months or until eligible for group coverage through another source including Medicare
<input type="radio"/> 3. Laid off employee	18 months or until eligible for group coverage through another source including Medicare	<input type="radio"/> 8. Widowed spouse of a State employee/retiree	36 months or until eligible for group coverage through another source including Medicare
<input type="radio"/> 4. Employee whose hours have been involuntarily reduced	18 months or until eligible for group coverage through another source including Medicare		
<input type="radio"/> 5. Divorce or legally separated spouse of a current State employee/retiree	Indefinitely or until eligible for group coverage through another source including Medicare		

The period of time is the number of months listed, or until eligible for coverage elsewhere, whichever is less.

LAWP - Long Term Leave Without Pay

If the long term LAWP is the result of a job-related accident or injury, the State will pay the State portion and the individual will pay the employee portion. If the long term LAWP is due to any other reason, the individual must pay 100 percent of the premium. In either case the employee will be billed by the Department of Budget & Management for the amount due.

AGENCY BENEFITS COORDINATOR - PLEASE PRINT THE FOLLOWING:

☐ for any other reason; describe:

C. Is this an initial LAWP? ☐ Yes ☐ No **OR** Is this an extension of a previous Long Term LAWP? ☐ Yes ☐ No

Date

Signature of Agency Benefits Coordinator or Appointing Authority

FISCAL OFFICER - PLEASE PRINT THE FOLLOWING (only if State subsidized LAWP)

Fiscal Officer Signature

ENROLLMENT FOR YEAR 2004**ENROLLMENT WORKSHEET****Dependent Information**

The following is reserved for dependent information. PLEASE PRINT. DO NOT TYPE. THIS MUST BE FILLED OUT TO INSURE YOUR DEPENDENTS ARE TRANSFERRED OVER TO THE PLANS FOR PROPER COVERAGE. You may use this section for additions(A), deletions (D), or changes (C) to your existing health benefits file for open enrollment or a qualifying event. Please print only - Dependents include spouse and children.

A/C/D	DC	LAST NAME	FIRST NAME	MI	SEX	BIRTH DATE	RELATIONSHIP	SOCIAL SECURITY NO.	COVER THIS DEPENDENT FOR:	HEALTH	DRUG	DENTAL

THIS MUST BE FILLED IN FOR PROPER COVERAGE. Students over age 25 are not eligible. Dependent children over age 19 must be full-time students or disabled.

Applicant and Agency Signatures

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member service representative before signing this application.

Please enroll me for the benefits indicated on this form. I understand the benefits and limitations provided by the various plans. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or to my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget & Management regulations. I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as the result of a qualifying change in family status permitted by Section 125 of the Internal Revenue Code.

I understand that the Benefits Program offered by the State is subject to modifications and changes and that the benefits I have chosen in this enrollment form are only in effect for calendar Year 2004. The State of Maryland reserves the right to modify any benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond calendar Year 2004. I certify that neither I nor my family members are covered under another State of Maryland employee's or retiree's membership.

I understand that enrollment in benefits to which I am not entitled is considered fraud. In all cases I am responsible for the accuracy of my benefits, coverage levels and deductions. I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my health benefits application, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be canceled, I will be required to repay any claims and insurance premiums, and I may face charges for dismissal from State service.

Is there any other health insurance in which you, your spouse or any of your dependents are enrolled? ☐ Yes ☐ No

Specify who is covered, name of Insurance Company and Policy Number: _____

X _____
Your Signature

_____/_____/_____
Date

- -
Your Work/Day Time Phone Number

X _____
AGENCY SIGNATURE - Agency Must Sign Here

_____/_____/_____
Date

- -
Work Phone Number (Ext.)

Agency Code:

Department

**COMPLETED AND SIGNED ENROLLMENT FORMS
SHOULD BE MAILED OR HAND-DELIVERED TO:**

**Employee Benefits Division
301 W. Preston Street
Room 510
Baltimore, Maryland 21201**